TRANSFER OF AUTHORITY TO OBTAIN DENTAL TREATMENT FOR A MINOR CHILD

I, _____, the Parent (Driver's License must be provided today)

of _____, a minor child, duly authorize the Florida Department of Health in Gulf County Dental Clinic staff to perform any routine or emergency dental procedure in my absence if escorted by one of the below family members.

The following individuals have my permission to escort said child to dental appointments, to approve, to discuss and to sign documents pertaining to the treatment and care of the child:

Name	Relationship to Child (Circle One)
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle
_____	Stepparent – Grandparent – Adult Brother/Sister – Adult Aunt/Uncle

The individual listed above must provide a Drivers License when bringing in minor child.

Signature _____ Print Name _____

Date_____

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:**_____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Florida Department of Health in Gulf County **Phone #:** (850)227-1276 or 639-2644

Address: 2475 Garrison Avenue, Port St Joe, FL 32456 or 807 Highway 22, Wewahitcka, FL 32465 **Fax #:** (850)227-1794 or 639-2357

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s)) _____

_____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

Client Name: _____

ID#: _____

DOB: _____